

# HEALTH RECORD FORM

Northern Illinois University, Lorado Taft Campus  
(815) 732-2111, extension 120

Student's Name \_\_\_\_\_

School \_\_\_\_\_

My child will attend the Lorado Taft Field Campus from \_\_\_\_\_ to \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Name of Parent or Guardian \_\_\_\_\_ Father's work phone \_\_\_\_\_

Guardian's work phone \_\_\_\_\_ Mother's work phone \_\_\_\_\_

Alternate Contact name and number \_\_\_\_\_

Our family physician is \_\_\_\_\_ Physician's phone \_\_\_\_\_

**The answers to these questions will be kept confidential. The purpose of these questions is to provide our nurse with health and safety information about your child.**

**IMPORTANT** - Please fill in date of last **TETANUS BOOSTER** \_\_\_\_\_

**1. See back side of form if child has asthma, an epi-pen or doctor's excuse from PE activities.**

2. Is your child presently under a doctor's care? \_\_\_\_\_ Yes \_\_\_\_\_ No

3. Medical information the **Taft nurse** should know about. (allergy, illness, physical disability, sleep walker, bedwetter, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

4. **SPECIAL DIET** (vegetarian, diabetic, food allergies, etc.) \_\_\_\_\_

5. **MEDICATIONS** - *I hereby give permission for my child to take medication at Lorado Taft Field Campus under the supervision of authorized personnel. All medication must be brought in a container appropriately labeled by a pharmacy or physician and clearly marked with the child's name and instructions for administering. IF YOUR CHILD IS PUT ON MEDICATION AFTER THE HEALTH FORM IS TURNED IN--SEND A NOTE WITH NAME, INSTRUCTIONS, AND PARENT SIGNATURE.*

**New protocol requires a doctor's signed medical note with exact dosages and time of day for any subcutaneous injections, intramuscular injections or nebulizer treatments. See back side of form.**

PLEASE LIST	Medication(s)	Directions for administering (specify am or pm)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Self-Administering Exception: Students with emergency-use inhalers and epi-pens must carry them at all times.

**"OVER THE COUNTER" Medications approved for student (please checkmark each type for approval):**

☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil, Motrin) ☐ Anti-itch cream ☐ Cough drops ☐ Benadryl allergy tabs

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***I give permission to have my child treated by the Lorado Taft Campus nurse,  
or by a physician in case of an emergency.***

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

**MEDICATIONS TO BE ADMINISTERED BY AUTHORIZED PERSONNEL SHOULD BE GIVEN TO THE  
TEACHER/COORDINATOR BEFORE DEPARTURE TO ENSURE SAFE ARRIVAL AT LORADO TAFT FIELD CAMPUS.**

**SCHOOL MEDICATION AUTHORIZATION FORM  
OUTDOOR EDUCATION FIELD TRIP – LORADO TAFT FIELD CAMPUS**

**NAME:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_

IF child is EXCUSED from PE for any reason, YOUR PHYSICIAN NEEDS to fill out, sign this release. **MD initials X**  
Name \_\_\_\_\_ has my permission to participate in outdoor education any  
limitations must be listed below:

\_\_\_\_\_

\_\_\_\_\_

**ASTHMA/INHALER SECTION**

Medication/Inhaler \_\_\_\_\_ Dosage \_\_\_\_\_ q \_\_\_\_\_ Hours

Neb Treatment – Name/Medication \_\_\_\_\_ Dosage \_\_\_\_\_ q \_\_\_\_\_ Hours

**ASTHMA ACTION PLAN Peak flow meter – My Personal Best =** \_\_\_\_\_

**Green Zone** – Breathing is easy, can play, work without symptoms **PEAK Flow Range 80%-100% of Personal Best**  
Medication/Nebulizer \_\_\_\_\_ Dose \_\_\_\_\_ Freq \_\_\_\_\_ Hours \_\_\_\_\_

**Yellow Zone** – Breathing easy, coughing or wheeze, chest tight, SOB **PEAK Flow Range 50%-80% of Personal Best**  
Medication/Nebulizer \_\_\_\_\_ Dose \_\_\_\_\_ Freq \_\_\_\_\_ Hours \_\_\_\_\_

**Red Zone** – Medicine NOT working, nose open wide to breath, breathing is hard and fast, trouble walking and talking, ribs show  
**IF SYMPTOMS DO NOT GET BETTER – CALL 911** **PEAK Flow Range below 50%**  
Medication/Nebulizer \_\_\_\_\_ Dose \_\_\_\_\_ Freq \_\_\_\_\_ Hours \_\_\_\_\_

**EPIPEN EMERGENCY PLAN SECTION Please note: each body system must be filled out**

**Allergic to:** \_\_\_\_\_

**Medication & Dosage:**

☐ Epipen 0.3mg ☐ Epipen Jr. 0.15mg ☐ Twinject 0.3mg ☐ Twinject 0.15mg ☐ Benadryl ☐ 25mg ☐ 50mg po

**Treatment:**

Mouth: Itching, tingling, or swelling of lips, tongue, mouth	GIVE	___ EPIPEN	___ TWINJECT	___ BENADRYL
Skin: Hives, itchy rash, swelling of the face or extremities	GIVE	___ EPIPEN	___ TWINJECT	___ BENADRYL
Gut: Nausea, abdominal cramps, vomiting, diarrhea	GIVE	___ EPIPEN	___ TWINJECT	___ BENADRYL
Throat: Tightening of throat, hoarseness, hacking cough	GIVE	___ EPIPEN	___ TWINJECT	___ BENADRYL
Lung: Shortness of breath, repetitive coughing, wheezing	GIVE	___ EPIPEN	___ TWINJECT	___ BENADRYL
Heart: Thready pulse, low blood pressure, fainting, pale, blueness	GIVE	___ EPIPEN	___ TWINJECT	___ BENADRYL
Other: _____	GIVE	___ EPIPEN	___ TWINJECT	___ BENADRYL
If reaction is progressing (several of the above areas affected)	GIVE	___ EPIPEN	___ TWINJECT	___ BENADRYL

**CALL 911, CALL PARENTS**

**OTHER INJECTIONS: Please list below or send a separate physicians order.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Physician Signature – Date**

\_\_\_\_\_  
**Parent Signature – Date**

(only needed if IM [including Epi Pens, diabetic injections, growth hormones, etc.],  
SubQ, nebulizer treatment, excuse from PE or if your school requires it)